Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: UTAH

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

Rod Betit, Executive Director, Utah Department of Health

SCHIP Program Name(s): Utah Children's Health Insurance Program (CHIP)

SCHIP Program Type:

____ Medicaid SCHIP Expansion Only
__X__ Separate SCHIP Program Only
____ Combination of the above

Reporting Period: Federal Fiscal Year 2001 (10/1/2000 - 9/30/2001)

Contact Person/Title: Chad Westover, Director

Address: Box 144102, Salt Lake City, UT 84114-4102

Phone: (801) 538-6689 Fax: (801) 538-6860

Email: cwestove@doh.state.ut.us

Submission Date: January 2, 2002

(Due to your CMS Regional Contact and Central Office Project Officer by January 1, 2002)
Please cc Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 2000, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

A. Program eligibility

Utah implemented an 40% deduction for self-employed or farm income in order to simplify the income verification process for families. Individuals may now elect to have 40% of their gross self-employment or farm income deducted for business expenses or they may choose to verify actual expenses. If an individual chooses to verify actual expenses, CHIP will allow any expenses that are authorized by the IRS.

B. Enrollment process **NC**

C. Presumptive eligibility **NC**

D. Continuous eligibility **NC**

E. Outreach/marketing campaigns

Utah CHIP has continued its focus on targeted, grass roots outreach. See responses to Section 2.4, 3.1-B, and 3.1-H for FFY 2001 outreach activities.

F. Eligibility determination process **NC**

G. Eligibility redetermination process **NC**

H. Benefit structure

The Utah Oral Health Summit was held this past year and concerns were discussed on dental coverage for SCHIP enrollees. The main issues were no benefit coverage for stainless steel crowns and limited coverage on dental extractions. This information was then presented to the CHIP Advisory Council in April 2001. After reviewing the benefit structure, stainless steel crowns and additional dental extraction codes were added to the CHIP benefits effective July 1, 2001.

I. Cost-sharing policies **NC**

J. Crowd-out policies **NC**

K. Delivery system **NC**

L. Coordination with other programs (esp. private insurance and Medicaid) **NC**

M. Screen and enroll process **NC**

N. Application

Utah added a notice to the CHIP application stating, "CHIP does not discriminate on the basis of race, ethnicity, religion, sex or disability."

O. Other **NC**

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children.

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

There has been no change on the rate of uninsured, low-income children during FFY 2001. The Utah Health Status Survey, a statewide health survey was recently conducted and new data will be available in 2002.

B. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

Currently there is no process in Utah to generate this data.

C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

Once the new data from the Health Status Survey is available, Utah will be able to reevaluate its uninsured rate.

D. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

X No, skip to 1.3

____ Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2: List the performance goals for each strategic objective.
Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter "NC" (for no change) in column 3*.

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
OBJECTIVES RELATED TO INCREASING CHIP ENROLLMENT AND REDUCING THE NUMBER OF UNINSURED CHILDREN IN UTAH		
1.0 Reduce the percentage of Utah children, from birth to 19 years of age who are uninsured.	1.1 By June 30, 1999, at least 10,000 previously uninsured low-income eligible children will be enrolled in Utah CHIP.	Performance Measure: Number of CHIP enrollees as of September 28, 2001 Progress: As of September 28, 2001, 25,640 eligible children were enrolled in Utah CHIP.

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)	
1.0 Reduce the percentage of Utah children, from birth to 19 years of age who are uninsured.	1.2 By June 30, 2000, the percentage of Medicaid eligible Utah children younger than 19 years of age who are enrolled in Medicaid will increase from 80 to 90 percent.	Performance Measure Progress	Number of Utah Medicaid enrollees as of September 28, 2001 As of September 28, 2001, 79,520 eligible children were enrolled in Utah Medicaid.
1.0 Reduce the percentage of Utah children, from birth to 19 years of age who are uninsured.	1.3 By June 30, 1999 the percentage of Utah children from birth to 19 years of age without health insurance will be decreased from 8.5 percent to 6 percent.	Performance Measure Progress	Number of Utah CHIP enrollees as of September 28,2001. The Department of Health is conducting a 2001 Health Status Survey which will provide CHIP with a new rate of uninsured children.
1.0 Reduce the percentage of Utah children, from birth to 19 years of age who are uninsured.	1.4 By December 31, 1998, a coordinated statewide outreach program from the identification and enrollment of CHIP eligible children into Utah CHIP will be established.	Performance Measure Progress	CHIP enrollment and CHIP hotline tallies. CHIP enrollment has continued to increase, with an average of more than 550 children enrolling each month. Calls received by the hotline increase more than 15% compared to FFY2000.
1.0 Reduce the percentage of Utah children, from birth to 19 years of age who are uninsured.	1.5 By December 31, 1998, a mechanism will be established to measure any change in rates of individuals purchasing or employers offering private insurance ("crowd-out"), that may be due to implementation of the Utah CHIP.	Performance Measure Progress	CHIP CAHPS phone survey. Utah CHIP has developed a CHIP specific CAHPS survey which will be administered every three years (last one was conducted in 1999). The next CHIP specific CAHPS Survey will be conducted in 2002.
OBJECTIVES RELATED TO INCREASING ACCESS TO HEALTH CARE FOR CHILDREN ENROLLED IN UTAH CHIP			
2.0 Increase access to health care services for Utah children enrolled in Utah CHIP.	2.1 By June 30,1999, at least 90 percent of children enrolled in Utah CHIP will have an identified usual source of care.	Performance Measure Progress	Percent of CAHIPS survey respondents who identify establishing a primary source of care. Utah CHIP has developed a CHIP specific CAHPS survey which will be administered every three years (last one was conducted in 1999). The next CHIP specific CAHPS Survey will be conducted in 2002.
2.0 Increase access to health care services for Utah children enrolled in Utah CHIP.	2.2 By June 30, 2000, there will be a decrease in the proportion of CHIP enrolled children who were unable to obtain needed medical care during the preceding year.	Performance Measure Progress	Percent of CAHPS survey respondents who indicate not having access to a primary sources of health care before and after enrolling in Utah CHIP. Utah CHIP has developed a CHIP specific CAHPS survey which will be administered every three years (last one was conducted in 1999). The next CHIP specific CAHPS Survey will be conducted in 2002.
2.0 Increase access to health care services for Utah children enrolled in Utah CHIP.	2.3 By June 30, 2000 at least 50 percent of five-year-old CHIP enrolled children will have received dental services prior to kindergarten entry.	Performance Measure Progress	HEDIS and Utah CHIP HMO encounter data for age appropriate Utah CHIP enrollees. Preliminary information is not available for this evaluation.

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)		(2) Performance Goals for each Strategic Objective		(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)	
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNICATIONS, WELL-CHILD CARE)					
3.0	Ensure the children enrolled in Utah CHIP receive timely and comprehensive preventive health care services.	3.1	By June 30, 2000, at least 50 percent of children who turned 15 month old during the preceding years and were continuously enrolled in Utah CHIP from 31 days of age, will have received at least four well-child visits with a primary care provider during the their first 15 months of life	Performance Measure Progress	HEDIS and encounter data for age appropriate Utah CHIP enrollees. Two of three CHIP managed care organizations are able to provide the required HEDIS information. The third HMO is working through programming issues.
3.0	Ensure the children enrolled in Utah CHIP receive timely and comprehensive preventive health care services.	3.2	By June 30, 2000, at least 60 percent of three, four, five, or six-year-old children who were continually enrolled in Utah CHIP during the preceding year, will have received at least one or more well-care visit with a primary care provider during the preceding year.	Performance Measure Progress	HEDIS and encounter data for age appropriate Utah CHIP enrollees. Two of three CHIP managed care organizations are able to provide the required HEDIS information. The third HMO is working through programming issues.
3.0	Ensure the children enrolled in Utah CHIP receive timely and comprehensive preventive health care services.	3.3	By June 30, 2000, at least 85 percent of two-year-old children enrolled in Utah will have received all age-appropriate immunizations.	Performance Measure Progress	HEDIS and encounter data for age appropriate Utah CHIP enrollees. Two of three CHIP managed care organizations are able to provide the required HEDIS information. The third HMO is working through programming issues.
3.0	Ensure the children enrolled in Utah CHIP receive timely and comprehensive preventive health care services.	3.4	By June 30, 2000, at least 90 percent of 13 year old children enrolled in Utah CHIP will have received a second dose of MMR.	Performance Measure Progress	HEDIS and encounter data for age appropriate Utah CHIP enrollees. Two of three CHIP managed care organizations are able to provide the required HEDIS information. The third HMO is working through programming issues.
3.0	Ensure the children enrolled in Utah CHIP receive timely and comprehensive preventive health care services.	3.5	By June 30, 2000, at least 50 percent of CHIP enrolled children eight years of age will have received protective sealant on at least one occlusal surface of a permanent molar.	Performance Measure Progress	Dental claims for the corresponding annual reporting period. Preliminary data is not available. The HMO for the CHIP dental network is working through HEDIS programming issues.
OBJECTIVE RELATED TO CHIP ENROLLED CHILDREN IN UTAH RECEIVING HIGH QUALITY HEALTH CARE SERVICES					
4.0	Ensure that CHIP enrolled children receive high quality health care services.	4.1	By June 30, 2000, the annual readmission rate for asthma hospitalizations among CHIP-enrolled children will have decreased compared to the rate during the previous year.	Performance Measure Progress	HEDIS and encounter data for Utah CHIP enrollees. Two of three CHIP managed care organizations are able to provide the required HEDIS information. The third HMO is working through programming issues.
4.0	Ensure that CHIP enrolled children receive high quality health care services.	4.2	By June 30, 1999, a set of quality care indictors will be selected and methods established for ongoing data collection and monitoring of these indicators.	Performance Measure Progress	HEDIS and encounter data for Utah CHIP enrollees. Two of three CHIP managed care organizations are able to provide the required HEDIS information. The third HMO is working through programming issues.

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)	
4.0 Ensure that CHIP enrolled children receive high quality health care services.	4.3 By June 30, 2000, at least 90 percent of CHIP enrollees surveyed will report overall satisfaction with their health care.	Performance Measure Progress	Percent of CAHPS survey respondents who indicate overall satisfaction with their health care for the reporting period. Utah CHIP has developed a CHIP specific CAHPS survey which will be administered every three years (last one was conducted in 1999). The next CHIP specific CAHPS Survey will be conducted in 2002.
OTHER OBJECTIVES			
5.0 Improve health status among children enrolled in Utah CHIP.	5.1 By June 30, 2000 no more than 20 percent of the Utah CHIP enrolled children ages six through eight years old will have untreated dental caries.	Performance Measure Progress	Dental claims for the corresponding annual reporting period. Preliminary data is not available. The HMO for the CHIP dental network is working through HEDIS programming issues.
5.0 Improve health status among children enrolled in Utah CHIP.	5.2 By June 30, 1999, a method will be established and a survey instrument developed and/or adapted for use in assessing over time and as compared to other groups of children.	Performance Measure Progress	CHIP specific CAHPS survey. Utah CHIP has developed a CHIP specific CAHPS survey which will be administered every three years (last one was conducted in 1999). The next CHIP specific CAHPS Survey will be conducted in 2002.
5.0 Improve health status among children enrolled in Utah CHIP.	5.3 By June 30, 1999, a set of child health status indicators will be selected and methods established for ongoing data collection and monitoring of these indicators. During the selection of health status indicators, careful consideration will be given to the particular health problems and areas of concern which significantly impact selected subgroups such as American Indians and other ethnic minorities, and children with special health care needs.	Performance Measure Progress	CHIP specific CAHPS survey. Utah CHIP has developed a CHIP specific CAHPS survey which will be administered every three years (last one was conducted in 1999). The next CHIP specific CAHPS Survey will be conducted in 2002.

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

Utah CHIP believes that it has and continues to meet all performance goals. The constraints in showing success will be realized once the third CHIP HMO is able to complete the necessary HEDIS programming.

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

No change.

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

The systems required for reporting and receiving quarterly and annual HEDIS age specific and diagnosis data has been completed by two of the three HMOs. The third HMO is resolving HEDIS programming problems and is making successful progress under the direction of Utah's CHIP Director. Based on meetings and conversations with the HMO the resolution to the HEDIS programming problem will be resolved by August 1, 2002.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

A. Utah CHIP Closure Report

B. Utah CHIP Enrollment Graph

C. Utah CHIP Enrollment Survey Results

D. Utah CHIP Hotline Tally and Found By Summary

E. Utah CHIP Renewal Flow Chart

F. Utah CHIP Retention and Disenrollment Report

G. 1999 Utah CAHPS Survey

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage: *N/A FOR UTAH CHIP*

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?

_____Number of adults
_____Number of children

C. How do you monitor cost-effectiveness of family coverage?

2.2 Employer-sponsored insurance buy-in: *N/A FOR UTAH CHIP*

A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

_____Number of adults
_____Number of children

2.3 Crowd-out:

A. How do you define crowd-out in your SCHIP program?

Crowd-out for Utah is defined as the substitution of public coverage (CHIP) for private or employee sponsored health coverage.

B. How do you monitor and measure whether crowd-out is occurring?

Utah has established a 90 day waiting period for all CHIP applicants who have voluntarily disenrolled from private coverage prior to applying for CHIP. At application CHIP applicants must identify if their child is currently insured and, if not, when the child was last covered and why that coverage was terminated.

As well, if health coverage is available to an applicant's dependents through an employer sponsored health plan, but the applicant has elected to not enroll their dependents in the plan, the cost of that coverage must exceed 5% of the applicant's income or the private coverage is considered affordable and the children are not eligible for CHIP.

C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

The most recent analysis of CHIP crowd out was done in FFY 2000. Utah conducted a survey of new CHIP applicants (at the time of initial application) from December 15, 1999 through January 31, 2000, to determine previous insurance coverage. The survey indicated that CHIP applicants are, on average, uninsured for 13 months prior to making application with CHIP.

The Utah CHIP enrollment survey results (attached) identified three primary groups of CHIP applicants:

1. Medicaid was the most recent coverage, income eventually exceeded Medicaid limit, and the employer sponsored health coverage exceeded 5% (22% of respondents.)
2. Medicaid was the most recent coverage, income eventually exceeded Medicaid limit, and the employer did not offer health coverage (36% of respondents.)
3. Most recent coverage was employer sponsored which was terminated due to job loss, employer dropped coverage, or coverage became too costly (29% of respondents.)

Only 3% of the survey respondents had terminated employer sponsored coverage within three months of applying for CHIP. This indicates that Utah CHIP applicants are not substituting CHIP coverage for a private, or employer sponsored insurance.

D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

There has been no indication of change regarding the absence of crowd out since the FFY 2000 survey, which clearly indicated that parents are not disenrolling their children from private coverage and waiting three months to apply for CHIP. As well, the CHIP benefit structure is similar to that of private and employer sponsored health insurance plans in order to further decrease the incentive to move from private sector plans to CHIP.

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

Utah's outreach activities during the 2001 FFY focused more on grass roots strategies in order for CHIP to reach deeper into the communities it serves. The primary communication activities consisted of individually targeting various community groups as well as directly communicating with families.

Organizations that have regular contact with potentially CHIP eligible families are a primary target for CHIP. Utah has found that the most successful communication is done with direct contact and partnership building. This was accomplished with one on one personal contact with every WIC clinic statewide, every school district, and various other community groups. (For additional information regarding Utah's success with WIC clinics and schools see response to Section 3.1-B.)

Producing a CHIP referral card and materials order form greatly aided communication between CHIP and other organizations. Both items were postcard size, self-addressed, and postage paid. The referral card was used for schools, Head Starts, and early intervention programs, but may be used by any public or private organization to refer families to CHIP. The referral card gives basic program information, eligibility criteria (including income limits), and a place for their name and address. Once the self-addressed, postage paid card is filled out and sent in, the family will receive a CHIP application and program information by mail. The referral card allows various organizations to give families a simple, direct contact to Utah's CHIP.

Communicating our ability to serve as a resource for information and materials was enhanced by the production of the postage paid, self-addressed materials order form. The card contains a listing of all the outreach materials available and gives the recipient an option to request a program representative come and speak to their organization. Requests have been received from doctors' offices, daycares, and virtually all other types of community groups. Each month averages over 30 requests for materials. During our back-to-school focus in September, over a 100 requests were received.

Communicating to families has also been more successful when done directly. A short introduction at a health fair or ad on the radio may prove to be enough for some families, but most need additional motivation before taking action. This is true when applying for a program or utilizing its services. To this end, CHIP attended fairs and offered presentations, but in addition, targeted families with a new semi-annual newsletter. Building upon the success of a postcard mailing done last FFY, CHIP produced and sent out a newsletter to all current enrollees, past enrollees, and community organizations. The newsletter included progress and enrollment data; information for enrollees such as the need to renew every 12 months, open enrollment, and who to contact when they have questions; as well as highlighting a CHIP family and our community based partners. The newsletter was designed to address areas of concern as they are identified and increase the amount of contact families have with Utah's CHIP program. The newsletter also included a copy of the referral card that families could cut out and pass on to someone they thought might be eligible. In the three months following the release of the newsletter, CHIP received 50 referral cards back requesting information for interested families.

B. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

Utah has found that the most successful way to reach further into any community is through the use of volunteers, and more specifically, volunteers who are members of the community you are trying to engage. This was particularly successful when holding a volunteer appreciation and back to school night in a community with a high Hispanic population. By using community volunteers from the local Boys and Girls Club who spoke Spanish, Hispanic families in the area not only knew about the event, but felt comfortable attending.

The volunteer appreciation event, mentioned above, was also successful in reaching the community groups who so often do much of our CHIP outreach. Recognizing the efforts of front line volunteers and organizations is a crucial element to building partnerships. Over 120 families, agencies, and volunteers were treated to dinner, games, and prizes. Utah's First Lady also attended the event and presented 18 community partnership awards to various organizations such as Utah PTA, Utah Hospital Association, and Utah Children.

C. Which methods best reached which populations? How have you measured effectiveness?

Continual reinforcement of the CHIP program has been the most successful means to reaching all populations. Great strides have been taken to form new partnerships and educate those community groups that CHIP has worked with in the past. To that end, Utah targeted those locations that working families were most likely to interact with, including families who have never experienced using a government program, i.e.- doctors' offices, day care centers, etc. New partnerships included meeting with and providing materials to the Parish Nursing Group in Salt Lake City who serve as a link to many resources for their church community, Utah State University extension students who conduct nutritional and home assessments, and VITA volunteers who offer free income tax assistance to lower income families. Each group is an example of those working directly with potentially CHIP eligible families, but prior to our contact, unsure of CHIP's qualifications, eligibility, and benefits.

Routine program updates and contact has helped to lead to an increase in awareness of children's health issues among community groups and families. One anecdotal illustration of this comes from an advocate who is involved with a group called Healthy Communities. She remarked that families and community leaders are becoming more active and interested in understanding their community's population. They are the ones who are requesting data from the various programs and are taking steps to become more educated so that their outreach becomes sustainable. In a sense, they are becoming true advocates for the communities they serve, which, in turn, has helped Utah CHIP enlarge our efforts.

2.5 Retention:

A. What steps is your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

Children on CHIP that are found to be eligible for Medicaid (and vice versa) are easily transferred to the other program through an electronic input from the same computer database management system and the same eligibility staff. In addition, two of the three CHIP health plans are also Medicaid health plans. Those children transferring between programs can maintain the same providers and facilities if they so choose.

If a family does disenroll for an unknown reason and do not reenroll within 60 days of their closure, they will receive a follow up phone call from a CHIP representative. If the household still qualifies, the CHIP representative will renew their eligibility over the phone.

B. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

_X_ Follow-up by caseworkers/outreach workers
_X_ Renewal reminder notices to all families
___ Targeted mailing to selected populations, specify population
_X_ Information campaigns
___ Simplification of re-enrollment process, please describe
_X_ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe:

Utah CHIP has participated in a Retention and Disenrollment SWOT Team facilitated by the National Association of State Health Policy (NASHP), and funded by the Packard Foundation. The SWOT Team has involved two Utah focus groups, one with CHIP disenrollees and the other with current CHIP enrollees, as well as a larger phone survey of these two populations.

Findings from the SWOT Team identified several needs for Utah including a need for greater communication with families, improved customer service, and streamlining the renewal process among the CHIP eligibility staff - especially the need to confirm whether a family has been renewed or not. However, focus group respondents described the form and renewal process as simple and straightforward.

C. Are the same measures being used in Medicaid as well? If not, please describe the differences.

Utah CHIP does not collect nor measure Medicaid data.

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

Utah redesigned its CHIP renewal form and established new renewal procedures during FFY 2000 in order to simplify and streamline the renewal process for the CHIP clients and the eligibility staff. These changes have shown a 3% decrease in disenrollment from September 2000 to September 2001. The new form, sent to CHIP clients at the end of the twelve month continuous enrollment period, includes the original eligibility information provided by the client during the initial application process. The CHIP client is asked to review the eligibility information and then contact their eligibility representative to verify that the information is still correct or clarify any changes that need to be made. The only circumstance in which a client is required to provide additional documentation is if there has been a job change and, in that situation, the CHIP client is required to submit income verification.

The current renewal process requires just one phone call from the CHIP client, which is not only convenient for the client but also much less administratively burdensome to the eligibility staff. Families have commented that it is much nicer not having to provide information that the program already has.

E. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

Utah CHIP conducts a monthly survey of all CHIP closures. Households who do not complete the renewal process are contacted by an eligibility representative (who also speaks Spanish) in order to determine why their renewal was not completed. If the family is still eligible for the program, the eligibility representative is able to renew the child(ren)'s coverage over the phone at that time.

The results of this survey (attached at the end of this report) indicate that the largest group of respondents, approximately one third, had obtained employer-sponsored coverage and, therefore, did not complete the renewal process for CHIP. Although the results of this survey show that CHIP is serving as a bridge to self-sufficiency for many families, there is concern over the large number of enrollees Utah is simply unable to locate.

2.6 Coordination between SCHIP and Medicaid:

A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

Utah uses a CHIP only application. If the financial information on that application is within Medicaid guidelines, the eligibility staff has the CHIP applicant complete an

addendum providing enough information to determine if, in fact, the applicant is eligible for Medicaid. This can be accomplished efficiently because Utah has the same eligibility staff for CHIP and Medicaid. The applicants like the short, non-bureaucratic CHIP application. If Utah were to have a joint CHIP/Medicaid application (with all the required eligibility information) the application would be 3 to 4 times longer; and there is concern that many potential applicants would be daunted by the application size and choose not to complete it. One can reason that separate applications may actually lead to more children being insured. The addendum acts as the bridge to Medicaid from CHIP, without having to burden the applicant with the additional Medicaid requirements.

B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

Children on CHIP that are found to be eligible for Medicaid (and vice versa) are easily transferred to the other program through an electronic input from the same computer database management system and the same eligibility staff.

C. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

Two of the three CHIP health plans are also Medicaid health plans. Those children transferring between programs may maintain the same providers and facilities if they so choose.

2.7 Cost Sharing:

A. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

Utah CHIP does not collect premiums from its enrollees or impose enrollment fees on its applicants.

B. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

To date, Utah CHIP has not collected this information, however, the effects of cost-sharing requirements on the utilization of medical services received by CHIP enrollees will be collected and evaluated through the CHIP CAHPS survey to be conducted during FFY 2002.

2.8 Assessment and Monitoring of Quality of Care:

A. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

The most recent information available that specifically addresses and measures the quality of care received by CHIP enrollees is contained in the 1999 CHIP CAHPS survey. The results of this survey were very encouraging and showed that 91.7% of survey respondents rated their satisfaction of Utah CHIP health care between 7 and 10, 10 being the highest. The next CHIP CAHPS survey will be conducted in FFY 2002.

B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

SCHIP has developed an individual CAHPS Survey to be performed every 3 years; the last survey was done in 1999. New data will be available for the FFY 2002 annual report.

C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

Future monitoring will be done by the CAHPS Survey. The next survey is scheduled for 2002 at which time updated data will be available.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

A. Eligibility

Utah uses a CHIP only, five question, application to determine eligibility. Anecdotal reports from applicants suggest that they like the short, non-bureaucratic CHIP application. The eligibility staff has also commented that individuals applying for Medicaid often inquire about how they can get the 'easy' application in reference to the CHIP application.

If the financial information provided on the CHIP application is within Medicaid guidelines, the eligibility staff has the CHIP applicant complete an addendum providing enough information to determine if, in fact, the applicant is eligible for Medicaid. This can be accomplished efficiently because Utah has the same eligibility staff for Medicaid and CHIP.

Building upon the success of the CHIP model, Medicaid has in turn made similar strides to simplify their application and enrollment process. Currently, a Medicaid Simplification Project is focusing on eliminating the unnecessary verification requirements placed on families.

B. Outreach

The ability to implement sustainable outreach efforts relies greatly on coordination with all other coverage programs, CHIP providers, state agencies and community organizations. Establishing direct contacts with these groups and systematically focusing on one entity at a time had helped Utah meet our outreach objectives this year.

The first entity chosen for this outreach and coordination effort was Utah's WIC clinics. Although most clinics were aware of CHIP, Utah wanted to establish contacts with each clinic statewide to provide program information and a link back to CHIP when questions arose or materials were needed. The CHIP Community Liaison personally visited all of the WIC clinics in the Weber, Davis, Salt Lake and Utah counties and contacted by phone all of the rural offices, offering information, outreach materials, and contact information. Follow up letters were also sent to maintain contact and affirm our willingness to help in any way needed.

Schools were the next choice for direct contact. Expanding outreach in the schools was a main focus not only because that's where the children are, but also because schools are a highly trusted entity within the community and they have contact with both children and parents. However, because schools have so many points of entry, establishing one central contact was a difficult task. CHIP contacted each of Utah's school districts to determine who would best serve as a contact, whether it was the superintendent for a smaller school district, a child nutrition director, or health service coordinator for another. Once again after the initial personal contact was made, a follow up letter and materials were sent to remind them of the resources available.

Efforts in school outreach have also focused on partnering with the school lunch program. Families qualifying for the free and reduced school lunch program are a prime target for outreach due to the similar income eligibility guidelines between the CHIP and school lunch programs. CHIP and Covering Kids Utah partnered together during August and September to focus on five targeted school districts. Three school districts sent out postage paid referral cards, which a family could fill out with their name and address and receive an application in return, and the remaining two school districts sent out fliers encouraging families to call the CHIP hotline for an application. Within the piloted school districts, cards or fliers were sent out to every family who applied for the school lunch program. In the months following the beginning of school, CHIP has received 175 requests for applications, of which 34 requested information in Spanish. Response to the flyers and other direct outreach to schools was measured through the CHIP hotline tallies. August of 2001, showed over a 7% increase in calls referred from schools coming into the CHIP hotline, in comparison to the same time the previous year. This response continued in September with a 10% increase in school calls, again compared to the same time the previous year. Although schools have always been a focus for CHIP outreach, this year through direct, personal contact with schools and coordination with the school lunch program Utah was able to significantly increase its level of awareness.

C. Enrollment

Enrollment projections were being met or exceeded during FFY 2001. As of September 28, 2001, more than 25,600 children were enrolled in CHIP.

D. Retention/disenrollment

The pre-printed renewal form and simplified renewal procedures implemented during FFY 2000 have helped to bring a 3% decrease in disenrollment from September 2000 to September 2001. The current renewal process requires just one phone call from the CHIP client, which is not only convenient for the client but also much less administratively burdensome to the eligibility staff. Families have also commented that it is much nicer not having to provide information that the program already has and that the process is simple, easy, and straightforward. However, despite the slight decrease in disenrollment, Utah will continue focusing on retention and improving upon the needs identified in a Retention and Disenrollment SWOT Team facilitated by the National

Association of State Health Policy (NASHP), and funded by the Packard Foundation. Findings included the need for increased communication with families, improved customer service, and streamlining the renewal process among the CHIP eligibility staff - especially the need to confirm whether a family has been renewed or not.

E. Benefit structure

The expansion to cover stainless steel crowns and additional extractions to the CHIP dental benefit were discussed in Section 1.1-H.

F. Cost-sharing

Cost sharing continues to be a valued form of enrollee participation for Utah's CHIP program. Utah includes cost sharing requirements in the form of co-payments and small co-insurance requirements (for example, Plan B enrollees are required to pay 10% of inpatient and outpatient hospital costs, up to the out of pocket annual maximum of $800.00). During two focus groups conducted this past year, both current and former parents of CHIP enrollees stated that they liked the fact that they had a co-payment because they were allowed to help themselves along the way.

G. Delivery system

No change.

H. Coordination with other programs

In March 2001, the CHIP outreach coordinator assumed the responsibilities of the Covering Kids Utah statewide project coordinator. This has greatly increased coordination and lessened duplication of efforts across many programs. Previously there were separate contacts for each program with little coordination and several questions regarding effective and appropriate outreach, now key stakeholders have increased their participation and the goals and strategies for both programs are set on an equal plain.

Due to the dual responsibilities of the CHIP outreach coordinator, the CHIP outreach subcommittee and Covering Kids outreach coalition were also combined into one, Outreach Coalition. This again lead to less duplication and greater results, especially for those individuals who served on both committees.

I. Crowd-out

Utah has established a three month waiting period for all CHIP applicants who have voluntarily disenrolled from private health coverage prior to applying for CHIP. At application, CHIP applicants must identify if their child is currently insured and, if not, when the child was last covered and why that coverage was terminated. As well, if health coverage is available to an applicant's dependents through an employer sponsored health plan, the cost of that coverage must exceed 5% of the applicant's income or the private

coverage is considered affordable and the children are not eligible for CHIP.

The most recent data collected on Utah CHIP crowd out during FFY 2000 clearly outlined the fact that families were not disenrolling their children from private coverage and waiting three months to apply for CHIP. As well, there has been no indication of change regarding these previous findings.

J. Other

N/A

SECTION 4: PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 **Please complete Table 4.1 to provide your budget for FFY 2001, your current fiscal year budget, and FFY 2002-projected budget. Please describe in narrative any details of your planned use of funds.**

Note: Federal Fiscal Year 2001 starts 10/1/00 and ends 9/30/01).

	Federal Fiscal Year 2001 costs	Federal Fiscal Year 2002	Federal Fiscal Year 2003
Benefit Costs			
Insurance payments			
Managed care	24,565,611	23,845,000	24,992,400
Per member/per month rate X # of eligibles			
Fee for Service			
Total Benefit Costs	24,565,611	23,845,000	24,992,400
(Offsetting beneficiary cost sharing payments)	(10,000)	(25,000)	(40,000)
Net Benefit Costs	24,555,611	23,820,000	24,952,400
Administration Costs			
Personnel	212,205	220,000	220,000
General administration	151,251	150,000	150,000
Contractors/Brokers (e.g., enrollment contractors)	1,979,401	1,850,000	1,850,000
Claims Processing			
Outreach/marketing costs	200,891	150,000	150,000
Other			
Total Administration Costs	2,543,748	2,370,000	2,370,000
10% Administrative Cost Ceiling	2,701,117	2,620,200	2,744,764
Federal Share (multiplied by enhanced FMAP rate)	21,682,197	20,690,500	21,322,400
State Share	5,417,162	5,500,000	5,500,000
TOTAL PROGRAM COSTS	27,099,359	26,190,500	27,322,400

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001.

NA FOR UTAH CHIP

4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

_X_ State appropriations
_____ County/local funds
_____ Employer contributions
_____ Foundation grants
_____ Private donations (such as United Way, sponsorship)
_____ Other (specify)

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

Utah does not anticipate any changes in the source of non-Federal share of plan expenditures.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Program Name		Utah Children's Health Insurance Program (CHIP)
Provides presumptive eligibility for children	_____No _____Yes, for whom and how long?	__**X**__No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No _____Yes, for whom and how long?	_____No __**X**__Yes, for whom and how long? ***4 days for emergency situations only.***
Makes eligibility determination	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*	__**X**__State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*
Average length of stay on program	Specify months	Specify months **11 months**
Has joint application for Medicaid and SCHIP	_____No _____Yes	__**X**__No _____Yes
Has a mail-in application	_____No _____Yes	_____No __**X**__Yes
Can apply for program over phone	_____No _____Yes	_____No __**X**__Yes ***However, they are required to sign a final application (faxed copies accepted).***
Can apply for program over internet	_____No _____Yes	__**X**__No ***Programming currently under way. Plans to launch in summer of 2002.*** _____Yes
Requires face-to-face interview during initial application	_____No _____Yes	__**X**__No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	_____No _____Yes, specify number of months What exemptions do you provide?	_____No __**X**__Yes, specify number of months: ***90 Days*** What exemptions do you provide? ***90 Day waiting period required only if coverage is voluntarily terminated.***

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Provides period of continuous coverage regardless of income changes	_____No _____ Yes, specify number of months Explain circumstances when a child would lose eligibility during the time period	_____No __**X**__Yes, specify number of months: **12** Explain circumstances when a child would lose eligibility during the time period. ***If children are enrolled in a private or employer sponsored coverage.***
Imposes premiums or enrollment fees	_____No _____Yes, how much? Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify)	__**X**__No _____Yes, how much? Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify)
Imposes copayments or coinsurance	_____No _____Yes	_____No __**X**__Yes
Provides preprinted redetermination process	_____ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	_____ No __**X**__ Yes, we send out form to family with their information and: __**X**__* ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed **** Confirmation from family may be done by telephone, mail, or in person.***

5.2 Please explain how the redetermination process differs from the initial application process.

The initial application process requires that each applicant submit documentation to verify age and citizenship of each child as well as household income. This information is used to determine initial eligibility. Those meeting the eligibility guidelines are then enrolled for twelve months of continuous eligibility.

Effective July, 2000, Utah implemented new CHIP renewal forms and procedures in order to simplify and streamline the renewal process for the CHIP clients and the eligibility staff. The new form, sent to CHIP clients the month prior to their twelfth month of continuous enrollment, includes the eligibility information provided by the client during the initial application process. The CHIP client is asked to review the information and then contact their eligibility representative to verify that the information is still correct or clarify any changes that need to be made. The only circumstance in which a client is required to provide additional documentation during their renewal is if there has been a job change. In that situation, the CHIP client is required to submit income and insurance information.

Prior to simplifying the renewal process, CHIP clients were required to reapply for coverage, including providing all required verification documents, even if their eligibility criteria had not changed since their initial enrollment. The current renewal process requires just one phone call from the CHIP client, which is not only convenient for the client but also much less administratively burdensome to the eligibility staff.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2001, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher

133 % of FPL for children under age 6
100 % of FPL for children aged 6 through 17
____ % of FPL for children aged _____

Medicaid SCHIP Expansion

____ % of FPL for children aged _____
____ % of FPL for children aged _____
____ % of FPL for children aged _____

Separate SCHIP Program

200 % of FPL for children aged 0 through 18
____ % of FPL for children aged _____
____ % of FPL for children aged _____

6.2 As of September 30, 2001, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA".*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)

____ Yes X No

If yes, please report rules for applicants (initial enrollment).

Table 6.2

	Title XIX Child Poverty-related Groups	Medicaid CHIP Expansion	Separate SCHIP Program
Earnings	$ 0.00	$	$ 0.00
Self-employment expenses	$ 0.00	$	$ 0.00
Alimony payments Received	$ 0.00	$	$ 0.00
Paid	$ 0.00	$	$ 0.00

Table 6.2			
Child support payments Received	Allow deduction of first $50.00	$	$ 0.00
Paid	$ 0.00	$	$ 0.00
Child care expenses ** Allow deduction of $200.00 per month per child age 0 to 2 ½ years, $175.00 per month per child above 2 ½ years if recipient is working full time. **Allow deduction of $160.00 per month per child age 0 to 2 ½ years, $140.00 per month per child above 2 ½ years if recipient is working part time.	$ **Age Based	$	$ 0.00
Medical care expenses	$	$	$ 0.00
Gifts *** Cash gifts up to $30.00 per household member per quarter.	$ ***	$	$ 0.00
Other types of disregards/deductions (specify)	None	$	None

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups

____ No __X__ Yes, specify countable or allowable level of asset test ____****

Medicaid SCHIP Expansion program

____ No ____ Yes, specify countable or allowable level of asset test_____

Separate SCHIP program

__X__ No ____ Yes, specify countable or allowable level of asset test_____

Other SCHIP program_____

____ No ____ Yes, specify countable or allowable level of asset test_____

**** Children 6 years to 18 years: $3,000 countable asset limit allowed for households of two (2), $25 per additional person.

6.4 Have any of the eligibility rules changed since September 30, 2001?

___ Yes __X__ No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2002 (10/1/01 through 9/30/02)? Please comment on why the changes are planned.

A. Family coverage

Family coverage has been discussed as part of the HRSA State Planning Grant. The additional utilization costs associated with family coverage, however, is proving to be a barrier to this approach.

B. Employer sponsored insurance buy-in

An employer-sponsored buy-in program is also an approach that has been discussed as part of the State's HRSA State Planning Grant. The administrative difficulty in approving each employer-sponsored health plan that may be involved in a buy-in option is a definite barrier. It is not anticipated that Utah will initiate a buy-in option for FFY 2002.

C. 1115 waiver

Utah's CHIP program does not anticipate submitting an 1115 waiver for FFY 2002.

D. Eligibility including presumptive and continuous eligibility

Utah is experiencing reductions in forecasted state revenues. This has necessitated the CHIP program to look at our continuous eligibility policy. Nothing definite has been decided. Presumptive eligibility is still not a consideration. Again, presumptive eligibility is seen more as a band-aid to more expeditious enrollment. It would seem CMS would be more effective in promoting more efficient enrollment procedures than in their promotion of presumptive eligibility.

E. Outreach

Given the above mentioned budget concerns, Utah's CHIP will be focusing on more targeted, grassroots outreach. The focus of outreach will be more to "inreach" by informing current enrollees about the renewal process and proper utilization of services.

F. Enrollment/redetermination process

As of December 10, 2001, Utah's CHIP has not been enrolling new applicants. This, again, is due to the continued reductions in forecasted state revenues. It is planned that Utah will hold an open enrollment period in July 2002 for new enrollment. Utah's renewal process may change but no definite decisions have been made.

G. Contracting

Utah's CHIP will be purchasing vaccines for enrollees through the Utah Immunization Program. This will reduce costs to CHIP and ensure wide access to immunizations throughout the state.

H. Other

N/A